DISABILITY REPORT - APPEAL - Form SSA-3441-BK

PLEASE READ ALL OF THIS INFORMATION BEFORE YOU BEGIN COMPLETING THIS FORM

IF YOU NEED HELP

If you need help with this form, do as much of it as you can, and your interviewer will help you finish it. However, if you have access to the Internet, you may access the Disability Report Form-Appeal instructions at http://www.socialsecurity.gov/online/ssa-3441.html.

HOW TO COMPLETE THIS FORM

We will use the information that you give us on this form to update your disability report information for your appeal. You can help us by completing as much of the form as you can.

- Please fill out as much of this form as you can before your interview appointment or before mailing in this form to Social Security.
- Print or type.
- **DO NOT LEAVE ANSWERS BLANK.** If you do not know the answers, or the answer is "none" or "does not apply," please write: "don't know," or "none," or "does not apply."
- **IN SECTION 3, PUT INFORMATION ON ONLY ONE DOCTOR/HOSPITAL/CLINIC IN EACH SPACE.**
- Each address should include a ZIP code. Each telephone number should include an area code.
- **DO NOT ASK A DOCTOR OR HOSPITAL TO COMPLETE THE FORM.** However, you can get help from other people, like a friend or family member.
- If your appointment is for an interview by telephone, have the form ready to discuss with us when we call you.
- If your appointment is for an interview in our office, bring the completed form with you or mail it ahead of time, if you were told to do so.
- When a question refers to "you," "your" or the "Disabled Person," it refers to the person who is applying for or has been entitled to disability benefits. If you are filling out the form for someone else, please provide information about him or her.
- Be sure to explain an answer if the question asks for an explanation, or if you want to give additional information.
- If you need more space to answer any questions or want to tell us more about an answer, please use the "REMARKS" section on Page 6, and show the number of the question being answered.

ABOUT YOUR MEDICAL RECORDS

If you have any medical records and copies of prescriptions at home for the person who is applying for or has been entitled to disability benefits, send them to our office with your completed form or bring them with you to your interview. Also, bring any prescription bottles with you. If you need the records back, tell us and we will photocopy them and return them to you. Please remember that this form is seeking **updated information since your last Disability Report**.

YOU DO NOT NEED TO ASK DOCTORS OR HOSPITALS FOR ANY MEDICAL RECORDS THAT YOU DO NOT ALREADY HAVE. With your permission, we will do that for you. The information we ask for on this form tells us to whom we should send a request for medical and other records. If you cannot remember the names and addresses of any of the doctors or hospitals, or the dates of treatment, perhaps you can get this information from the telephone book, or from medical bills, prescriptions and prescription bottles.

The Privacy And Paperwork Reduction Acts

The Social Security Administration is authorized to collect the information on this form under sections 205(a) and (b), 223(d) and 1631(e)(1) of the Social Security Act. The information on this form is needed by Social Security to make a decision on the named claimant's claim. Giving us the information on this form is mandatory. Although the information you furnish is almost never used for any purpose other than making a determination about the claimant's disability or continuing disability, such information may be disclosed by the Social Security Administration as follows: (1) to enable a third party or agency to assist Social Security in establishing rights to Social Security benefits and/or coverage; (2) to comply with Federal Laws requiring the release of information from Social Security records (e.g., to the General Accounting Office and the Department of Veterans Affairs); and (3) to facilitate statistical research and such activities necessary to assure the integrity and improvement of the Social Security programs (e.g., to the Bureau of the Census and private concerns under contract to Social Security).

We may also use the information you give us when we match records by computer. Matching programs compare our records with those of other Federal, State, or local government agencies. Many agencies may use matching programs to find or prove that a person qualifies for benefits paid by the Federal government. The law allows us to do this even if you do not agree to it.

Explanations about these and other reasons why information you provide us may be used or given out are available in Social Security offices. If you want to learn more about this, contact any Social Security office.

Paperwork Reduction Act Statement: This information collection meets the requirements of 44 U.S.C. § 3507, as amended by Section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 30 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. The office is listed under U. S. Government agencies in your telephone directory or you may call Social Security at 1-800-772-1213.** *You may send comments on our time estimate above to: SSA, 1338 Annex Building, Baltimore, MD 21235-0001. Send only comments relating to our time estimate to this address, not the completed form.*

PLEASE REMOVE THIS SHEET BEFORE RETURNING THE COMPLETED FORM.

SOCIAL SECURITY ADMINISTRATION

Form Approved
OMB No. 0960-0144

DISABILITY REPORT- APPEAL

For SSA Use Only
Do not write in the shaded area.
Related SSN _____
Number Holder _____

Date of Last Disability Report _____

Claimant is filing: ☐ **Reconsideration** ☐ **Reconsideration for Disability Cessation** ☐ **Request for ALJ Hearing**

SECTION 1- INFORMATION ABOUT THE DISABLED PERSON

A. NAME *(First, Middle Initial, Last)*

B. SOCIAL SECURITY NUMBER

C. DAYTIME TELEPHONE NUMBER *(If you have no number where you can be reached, give us a daytime number where we can leave a message for you.)*

Area Code _____ *Number* _____ ☐ Your Number ☐ Message Number ☐ None

D. Give the name of a friend or relative that we can contact (other than your doctors) **who knows about your illnesses, injuries or conditions** and can help you with your claim.

NAME _____ RELATIONSHIP _____

ADDRESS _____
(Number, Street, Apt. No.(If any), P.O. Box, or Rural Route)

_____ _____ _____ DAYTIME PHONE _____ _____
City *State* *ZIP* *Area Code* *Number*

SECTION 2- INFORMATION ABOUT YOUR ILLNESSES, INJURIES, OR CONDITIONS

A. Has there been any change (for better or worse) in your illnesses, injuries, or conditions **since you last completed a disability report?** ☐ Yes ☐ No

If **"Yes,"** please describe in detail:

_____

_____

Approximate date the changes

Month	Day	Year

B. Do you have any new physical or mental limitations as a result of your illnesses, injuries, or conditions **since you last completed a disability report?** ☐ Yes ☐ No

If **"Yes,"** please describe in detail:

_____

_____

Approximate date the changes

Month	Day	Year

C. Do you have any new illnesses, injuries or conditions **since you last completed a disability report?** ☐ Yes ☐ No

If **"Yes,"** please describe in detail:

_____

_____

Approximate date the changes

Month	Day	Year

If you need more space, use Remarks, Section 10.

SECTION 3 - INFORMATION ABOUT YOUR MEDICAL RECORDS

A. Since you last completed a disability report, have you been seenor will you see a **doctor/hospital/clinic** or anyone else for the illnesses, injuries or conditions that limit your ability to work? ☐ YES ☐ NO

B. Since you last completed a disbility report, have you seen or will you see a **doctor/hospital/clinic** or anyone else for emotional or mental problems that limit your ability to work? ☐ YES ☐ NO

C. List **other names** you have used on your medical records.

If you answered "NO" to both A and B, go to Section 4.

Tell us who may have medical records or other information about your illnesses, injuries or conditions **since you last completed a disability report.**

D. List each DOCTOR/HMO/THERAPIST/OTHER. Include your **next appointment.**

1.

NAME			DATES
STREET ADDRESS			**FIRST** VISIT
CITY	**STATE**	**ZIP**	**LAST** SEEN
PHONE ___ ___ *Area Code* *Phone Number*	**PATIENT ID #** (If known)		NEXT **APPOINTMENT**
REASONS FOR VISITS			
WHAT **TREATMENT** WAS RECEIVED?			

2.

NAME			DATES
STREET ADDRESS			**FIRST** VISIT
CITY	**STATE**	**ZIP**	**LAST** SEEN
PHONE ___ ___ *Area Code* *Phone Number*	**PATIENT ID #** (If known)		NEXT **APPOINTMENT**
REASONS FOR VISITS			
WHAT **TREATMENT** WAS RECEIVED?			

If you need more space, use Remarks, Section 10.

E. List each HOSPITAL/CLINIC. Include your **next appointment.**

HOSPITAL/CLINIC			TYPE OF VISIT	DATES	
NAME			☐ **INPATIENT** STAYS *(Stayed at least overnight)*	DATE IN	DATE OUT
STREET ADDRESS					
			☐ **OUTPATIENT** VISITS *(Sent home same day)*	DATE FIRST VISIT	DATE LAST VISIT
CITY	STATE	ZIP			
			☐ **EMERGENCY ROOM** VISITS	DATE OF VISITS	
PHONE					
Area Code *Phone Number*					

Next **appointment** _____ Your hospital/clinic **number** _____

Reasons for visits _____

_____

What **treatment** did you receive? _____

_____

What **doctors** do you see at this hospital/clinic on a regular basis? _____

_____

If you need more space, use Remarks, Section 10.

F. Since you last completed a disability report, does **anyone else have medical records or information** about your illnesses, injuries, or conditions (Worker's Compensation, insurance companies, prisons, attorneys, or welfare agency), or are you scheduled to see anyone else?

☐ YES ☐ NO If **"YES,"** complete information below:

NAME			DATES
STREET ADDRESS			**FIRST** VISIT
CITY	**STATE**	**ZIP**	**LAST** SEEN
PHONE *Area Code* *Phone Number*			NEXT **APPOINTMENT**
CLAIM NUMBER (If any)			
REASONS FOR VISITS			

If you need more space, use Remarks, Section 10.

SECTION 4 - MEDICATIONS

Are you currently taking any **medications** for your illnesses, injuries or conditions? ☐ YES ☐ NO

If **"YES,"** please tell us the following: *(Look at your medicine bottles, if necessary.)*

NAME OF MEDICINE	IF PRESCRIBED, GIVE NAME OF DOCTOR	REASON FOR MEDICINE	SIDE EFFECTS YOU HAVE

If you need more space, use Remarks, Section 10.

SECTION 5 - TESTS

Since you last completed a disability report, have you had any **medical tests** for illnesses, injuries or conditions or do you have any such tests scheduled?

If **"YES,"** please tell us the following: *(Give approximate dates, if necessary.)* ☐ YES ☐ NO

KIND OF TEST	WHEN DONE, OR WHEN WILL IT BE DONE? (Month, day, year)	WHERE DONE? (Name of Facility)	WHO SENT YOU FOR THIS TEST?
EKG (HEART TEST)			
TREADMILL (EXERCISE TEST)			
CARDIAC CATHETERIZATION			
BIOPSY--Name of body part _____			
HEARING TEST			
SPEECH/LANGUAGE TEST			
VISION TEST			
IQ TESTING			
EEG (BRAIN WAVE TEST)			
HIV TEST			
BLOOD TEST (NOT HIV)			
BREATHING TEST			
X-RAY--Name of body part _____			
MRI/CT SCAN Name of body part _____			

If you need more space, use Remarks, Section 10.

SECTION 6 - UPDATED WORK INFORMATION

A. Have you worked **since you last completed a disability reort?**

☐ YES ☐ NO

If **"YES,"** you will be asked to give details on a seperate form.

SECTION 7 - INFORMATION ABOUT YOUR ACTIVITIES

A. How do your illnesses, injuries, or conditions affect your ability to care for your personal needs?

B. What changes have occurred in your daily activities **since you last completed a disability report?**

If none, show **"NONE."**

If you need more space, use Remarks, Section 10.

SECTION 8-EDUCATION/TRAINING INFORMATION

Have you completed any type of **special job training, trade or vocational school since you last completed a disability report?** ☐ YES ☐ NO

If **"YES,"** describe what type: _____

Approximate **date** completed: _____

SECTION 9 - VOCATIONAL REHABILITATION, EMPLOYMENT, or OTHER SUPPORT SERVICES INFORMATION

Since you last completed a disability report, have you participated in the Ticket Program or another program of vocational rehabilitation services, employment services or other support services to help you go to work?

☐ YES ☐ NO

If "**YES**," complete the following information:

NAME OF ORGANIZATION _____

NAME OF COUNSELOR _____

ADDRESS _____

(Number, Street, Apt. No.(if any), P.O. Box or Rural Route)

_____

City *State* *Zip*

DAYTIME PHONE NUMBER _____ _____

Area Code *Number*

DATES SEEN _____ TO _____

TYPE OF SERVICES OR TESTS PERFORMED _____

(IQ, vision, physicals, hearing, workshops, etc.)

SECTION 10 - REMARKS

Use this section for any added information you did not show in earlier parts of the form. When you are done with this section (or if you don't have anything to add), be sure to go to the next page and complete the blocks there.

SECTION 10 - REMARKS

Name of person completing this form *(Please Print)*	**Date Form Completed** *(Month, day, year)*
Address *(Number and street)*	**e-mail address** *(optional)*
City **State**	**Zip Code**